Sherwood Forest Hospitals NHS
NHS Foundation Trust

Sherwood Rehabilitation Team

Case study 2

Retired miner Mr Y, aged 78, had a stroke 12 years ago. He also had a heart attack when he was 66, and has emphysema, chronic low back pain and osteoarthritis affecting his knees and hips. He is regularly seen by the Community Nursing team at his own home, who have referred Mr Y for assessment as he has been sleeping in a chair, unable to access his bedroom or bathroom upstairs for several weeks due to recurrent urinary tract infections, shortness of breath and generalised pain and stiffness in his legs. He lives with his wife who is also disabled.

Problems identified and intervention provided:

- Seated and supported standing targeted individualised home exercise programme to improve lower limb strength
- Provision of wheeled walking aid, additional stair rail, chair raise, perching stool and bed lever to enable access to upstairs and to get in/out of bed
- Referral to Social Services for assessment of bathing and carers assessment for his wife—additional equipment provided to facilitate access to bath and weekly carers to support this
- Following intervention in the home setting for 6 weeks, Mr Y felt able to attend the hospital outpatient department for a further 6 weeks where he was able to progress to mobilising with a 3 wheeled walking frame which he could use for short distances outdoors to enable access to a car

Objective outcome measures after intervention demonstrated that balance and confidence had improved and Mr Y felt that his overall quality of life was 'back to normal' with increased independence and less reliance on his wife

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Sherwood Rehabilitation Team

Promoting independence for older people in the community

Referral Criteria

Patients should be:

- medically stable and fit for rehab
- have age-related pathology and potential to benefit from specialist Physiotherapy and / or Occupational Therapy intervention
- Community resident (eg own home, supported accommodation, residential or nursing home

Service outline

We are based at Mansfield Community Hospital, and offer outpatient treatment in the Rehab Suite or in the patients own home. Patients are assessed by the MDT and a joint decision is made about intensity and type of intervention required. A therapy plan and goals are agreed with the patient, and function is re-assessed following a period of rehab.

We see patients with a variety of problems including musculoskeletal disorders, respiratory problems, neurological conditions and mental health problems

Tel: 01623 785122 Fax: 01623 785180

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Outreach Service

Patient's can be seen in the community if they meet the referral criteria, but have additional needs such as:

- Psychological state and /or mental health problem eg anxiety
- Housebound due to poor mobility or access problems eg steps
- Equipment or assessment required specific to home environment eg grab rails, bed levers, toilet transfers
- Nursing and Residential Home patients may be seen in the home so that appropriate training and advice can be offered to residential support staff / carers
- Severe incontinence / sickness issues indicating that travelling to hospital would not be feasible

After initial assessment, patients usually attend for a 6 – 8 weekly sessions, and are usually then invited to attend for MDT re-assessment following a break of 6 – 8 weeks. Goals and function can then be revisited, and re-evaluated as appropriate.

Patient satisfaction survey

In a recent survey (Jan-May 2016) the majority of comments received from patients were positive:

- 82% of people reporting quality of life was better than before starting treatment
- 100% felt staff had listened, and showed care and compassion
- 93% of people were 'very satisfied' with the overall service they received
- 'Absolutely brilliant, caring, thoughtful and helpful'

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Sherwood Rehabilitation Team

Case study 1

69 year old Mrs X was referred to the service by her GP following a consultation when she revealed that she was fearful of falling and had stopped going out due to a lack of confidence. She has a history of osteoarthritis and left elective knee replacement surgery 5 years ago, diverticular disease and osteoporosis.

3 weeks after the referral was received, an appointment was offered and problems identified on assessment were generalised muscle atrophy in lower limbs, bilateral knee and hip pain, lack of confidence, struggling with toilet and bed transfers, poor posture and mobility. Mrs X agreed to attend the outpatient department with the support of her daughter for 6 weekly sessions and intervention included:

- a seated and supported standing home exercise programme
- provision of a wheeled walking frame, toilet frame and bed lever
- postural and gait re-education
- pain management advice such as pacing and loan of TENS unit
- dynamic balance work with therapy staff support in rehab dept

Following intervention, gait, balance, confidence and pain management were found to have improved demonstrated by objective, validated outcome measures. As a result of these improvements, Mrs X felt able to attend her social club and go on short shopping trips with friends, which she had stopped doing several months ago. She also reported her pain levels were significantly lower than prior to intervention, and consequently, her use of analgesia had reduced, and her quality of life had been enhanced.